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In the Supreme Court of the United States

OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, ET AL., PETITIONERS

v.

TRAVELERS INSURANCE CO., ET AL.

MARIO M. CUOMO, ET AL., PETITIONERS

v.

TRAVELERS INSURANCE CO., ET AL.

HOSPITAL ASSOCIATION OF NEW YORK, PETITIONER

v.

TRAVELERS INSURANCE CO., ET AL.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTIONS PRESENTED

In three related statutes, New York State law imposes different surcharges on the rates hospitals charge, depending on whether the charges are paid by commercial insurers, health maintenance organizations, self-insured funds, or other specified payors. The questions presented are:

1. Whether the surcharges, which apply to hospital care regardless of whether it is provided pursuant to an Employee Retirement Income Security Act (ERISA) plan, are preempted by ERISA insofar as the hospital charges are covered by an ERISA plan.

2. Whether the surcharges are preempted by the Federal Employees Health Benefit Act (FEHBA), insofar as they apply to hospital care covered by a FEHBA plan.

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BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

This brief is submitted in response to the Court's invitation to the Solicitor General to express the views of the United States.

STATEMENT

1. New York State has a "comprehensive statutory scheme for the regulation of in-patient hospital rates." Pet. App. A64-A65.[1] For each of 794 diagnostic related groups (DRGs), a uniform rate is set that reflects the average cost of treating a patient with a particular diagnosed condition, adjusted for each hospital to reflect factors such as its operating costs, capital costs, malpractice costs, and bad debt and charity care costs. The rate for a particular DRG thus varies from hospital to hospital. In general, patients entering a hospital are assigned a DRG according to their condition, and are billed at the DRG rate for that particular hospital, rather than for the actual cost of treatment. *Id.* at A65.

In 1988 and 1992, the New York legislature enacted legislation that required that hospital rates be calculated according to not only the DRG rate for the patient and hospital, but also the party paying for the services. The legislation prescribed three surcharges to be added to hospital rates:

First, a 13% surcharge was imposed on all hospital bills paid by a commercial insurer, by "a self-insured fund" that directly reimburses hospitals, or by any of a number of specialized payment schemes, including workers' compensation, volunteer firefighters' and ambulance workers' benefits, and no-fault motor vehicle insurance. N.Y. Pub. Health Law § 2807-c(1)(b) (McKinney 1993) (Pet. App. A102). The surcharge is paid to the hospital and retained by it. Having been renewed once, the surcharge, along with the balance of New York's hospital cost regulations, will expire on December 31, 1995, unless it is extended. 1993 N.Y. Laws, ch. 731, § 35.

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[1] All references to "Pet. App." are to the appendix to the petition for a writ of certiorari in No. 93-1414.

Second, an additional surcharge of 11% was imposed on hospital bills paid by commercial insurers, raising the total surcharge for such payors to 24%. 1992 N.Y. Laws, ch. 55 § 348 (Pet. App. A104). That surcharge was to be paid to the hospital, which was then to pay it into the State's general fund. The 11% surcharge was imposed for a one-year period that ended on March 31, 1993. *Ibid.*

Third, rates for services rendered to members of health maintenance organizations (HMOs) were surcharged 0% to 9%, depending on how close the particular HMO came to meeting its target for enrollment of Medicaid recipients. N.Y. Pub. Health Law § 2807-c2-a(a)-(e) (McKinney 1993) (Pet. App. A106-A113). The 0% to 9% surcharge was paid by the HMO directly into a statewide pool, and then into the state treasury. N.Y. Pub. Health Law § 2807-c2-a(c) (McKinney 1993) (Pet. App. A111). Under current law, the surcharge on HMOs will expire on December 31, 1995, unless it is extended. 1993 N.Y. Laws, ch. 731, § 35.

Some hospital bills are not subject to any surcharge. Services covered by Medicaid or a Blue Cross/Blue Shield plan (the Blues) are billed at the DRG rate without a surcharge. N.Y. Pub. Health Law § 2807-c(1)(a) (McKinney 1993) (Pet. App. A101). Services rendered to all other patients, including patients who pay their own bills or are covered by self-insured funds or commercial insurers that reimburse the patient rather than the hospital, are subject to the hospital's own charges (not the DRG rate), with a statutory limit higher than that charged to commercial insurers. N.Y. Pub. Health Law § 2807-c(1)(c) (McKinney 1993) (Pet. App. A103).

The purpose of the 13% surcharge is "to contain hospital costs and to increase the availability of hospital insurance coverage to needy New Yorkers" by making the Blues—which are required by the State to engage in open enrollment, making them the "insurer of last resort" for high-risk individuals, see Pet. App. A28—more competitive with com-

mercial insurers. The 11% surcharge had a similar purpose, and also was designed to increase state revenues. By comparison, "the primary purpose of the 9% assessment [is] to encourage HMOs to enroll Medicaid recipients, thereby lowering the costs of the Medicaid program." *Id.* at A7-A8.

2. a. This case principally presents the question whether the 13%, 11%, and 9% surcharges are preempted by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.* ERISA generally governs employee benefit plans, see 29 U.S.C. 1003(a), including any employee welfare benefit plan "established or maintained by an employer * * * for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, * * * medical, surgical, or hospital care or benefits." ERISA § 3 (1), 29 U.S.C. 1002(1). ERISA plans pay for a large percentage of hospital bills in New York State. Pet. App. A6. "ERISA plans provide health coverage to employees in various ways, including: (1) the purchase of commercial health insurance from an insurer; (2) self-insurance, whereby the plan is directly responsible for health care bills * * *; (3) subscription to a health maintenance organization * * *; and (4) coverage through non-profit health service corporations, such as Blue Cross/Blue Shield plans." Pet. App. A6-A7. Thus, ERISA plans that provide hospitalization benefits either are themselves payors of hospital bills or are purchasers of hospitalization coverage from commercial insurers or other payors.

The primary preemption provision of ERISA is Section 514(a), 29 U.S.C. 1144(a). It states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. The insurance savings clause of ERISA, § 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A), however, limits the reach of the preemption clause. The savings clause states that, except as provided in the "deemer clause," described

below, ERISA does not "exempt or relieve any person from any law of any State which regulates insurance." See App., *infra*, 1a. Finally, what has come to be known as the "deemer clause," ERISA § 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B), makes a distinction between "an insurance company or other insurer * * * engaged in the business of insurance," to which the saving clause applies, and "an employee benefit plan," which shall not be "deemed" to be an insurance company or engaged in the business of insurance for preemption purposes. See App., *infra*, 1a. Thus, state regulation of the business of insurance is not preempted except insofar as it applies to employee benefit plans themselves. See *FMC Corp.* v. *Holliday*, 498 U.S. 52, 61-63 (1990).

b. This case also concerns whether the 13% and 11% surcharges are preempted by the FEHBA. Under 5 U.S.C. 8909(a) (Supp. IV 1992), an "Employees Health Benefits Fund which is administered by the Office of Personnel Management [OPM]" is established in the Treasury, to receive government and federal employee contributions for medical benefits. OPM in turn contracts with various carriers to offer health benefit plans that pay the cost of medical services for covered federal employees. With respect to the experience-rated health benefit plans at issue in this case, the carrier first pays for a covered medical service and is then reimbursed by withdrawing from the Employees Health Benefits Fund in the Treasury. Pet. App. A14-A15 & n.3.

FEHBA's primary preemption provision was added in 1990. See Pub. L. No. 101-508, Tit. VII, § 7002(c), 104 Stat 1388-330, codified at 5 U.S.C. 8909(f) (Supp. IV 1992). As relevant here, it provides that "[n]o tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or an underwriting or plan administration subcontractor of an approved [FEHBA] health benefits plan, * * * with respect to any payment made from the Fund." 5 U.S.C. 8909(f)(1) (Supp. IV 1992).

On July 29, 1992, the New York Department of Health asked OPM for a written opinion regarding the preemptive effect of Section 8909(f). C.A. App. 1545. On August 25, 1992, OPM replied that "the assessments imposed by the State of New York on the hospital bills paid by FEHB plans * * * are preempted by Federal law" because they "impose[] payment obligations on insurers with respect to payments to the insurer from the FEHB Fund." C.A. App. 1546.

3. In two actions later consolidated in the federal district court, the respondent insurance companies and their trade association sought to invalidate and enjoin enforcement of the three surcharges on grounds that the surcharges are preempted by ERISA and FEHBA. The other respondents (New York State Health Maintenance Organization Conference and several HMOs) intervened in support of the insurers, and the New York State Conference of Blue Cross and Blue Shield Plans, Empire Blue Cross and Blue Shield, and the Hospital Association of New York intervened on behalf of New York State. On cross-motions for summary judgment, the district court held, as pertinent here, that ERISA preempts all three surcharges, and it enjoined their enforcement "against any commercial insurers or HMOs in connection with their coverage of any ERISA plans." Pet. App. A89-A90. The district court also held that FEHBA preempts the 13% and 11% surcharges. *Id.* at A86.

4. a. The court of appeals affirmed the district court's ruling that ERISA preempts all three surcharges. The court held that, although the surcharge statutes "do not refer to ERISA plans," Pet. App. A22, they "relate to" ERISA plans within the meaning of Section 514(a) because they "satisfy the less stringent 'connection with' standard embraced in *Ingersoll-Rand* [*Co.* v. *McClendon*, 498 U.S. 133 (1990)]." *Ibid.* The court found the requisite connection in the fact that, because the surcharges were designed to increase hospital costs for patients not covered by the Blues, "the surcharges purposely

interfere with the choices that ERISA plans make for health care coverage," *ibid.*, and force ERISA plans "to increase either plan costs or reduce plan benefits," *id.* at A23. The court rejected the argument that indirect economic impact alone does not suffice to justify a finding of preemption. *Id.* at A23-A24. Thus, it concluded that the "three surcharges 'relate to' ERISA because they impose a significant economic burden on commercial insurers and HMOs. They therefore have an impermissible impact on ERISA plan structure and administration." *Id.* at A24.

The court also ruled that the 11% and 13% surcharges are not saved from preemption under Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A), as laws "which regulate[] insurance." It held that the surcharges are not insurance laws as a matter of "common-sense" because they regulate hospital rates and are not directed at the insurance industry. Pet. App. A26-A27. The court rejected the argument that laws "designed to affect the insurance marketplace by giving the Blues a competitive advantage over * * * other players in the marketplace" amount to regulation of the "business of insurance" within the meaning of ERISA's savings clause. *Id.* at A27.

The court reached the same conclusion after applying the three traditional factors for determining whether a state insurance law is protected by the McCarran-Ferguson Act, 15 U.S.C. 1012, which this Court has found applicable under ERISA's insurance savings clause as well. See *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 48-49 (1987). The court agreed with petitioners that the first factor—"risk spreading"—supports the validity of the surcharges, because they spread risk by encouraging plans to shift to the Blues. Pet. App. A28. In the court's view, however, the second factor is not satisfied because the surcharges "do not regulate any practice that is integral to the insurer-insured relationship." *Ibid.* The court reasoned that the surcharges do not directly affect the "terms, conditions or scope of coverage in commercial

insurance contracts," and "relate only to the contractual obligations between hospitals and insurers or insureds," rather than the relationship between the insurers and insureds. *Id.* at A29. Finally, the court held that the third factor is not satisfied, reasoning that the surcharges are not " limited to entities within the insurance industry," because the surcharges affect non-insurance entities such as "the State, hospitals, patients, HMOs, and self-insured funds." *Ibid.*

In two footnotes, the court approved the district court's holding that the 9% surcharge affecting only HMOs is not saved because HMOs do not engage in the business of insurance "as a matter of law." Pet. App. A26 n.5, A29 n.6. In reaching that conclusion, the court specifically rejected the position of the Secretary of Labor as amicus curiae that, regardless of how HMOs may be treated for other purposes, they were, in the context of this case, "person[s]" subject to State laws "which regulate insurance," within the meaning of the insurance savings clause. *Id.* at A26 n.5.[2]

b. On the FEHBA issue, the court of appeals held that "[b]ecause payments from the [FEHBA] Fund are directly affected by what the hospitals charge for their services, and because the surcharges increase the amounts carriers draw from the Fund, the surcharges are clearly imposed 'with

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[2] The district court had stayed its judgment as to the 13% surcharge and ordered that funds from the 9% and 11% surcharges be paid into escrow. Pet. App. A98. The court of appeals stayed its mandate pending the filing and disposition of petitions for writs of certiorari. HANYS Reply Br. 6. Congress amended the Internal Revenue Code to provide that employers will lose certain plan-related tax deductions if their plans do not pay the New York surcharges due for hospital services rendered between February 2, 1993, and May 12, 1995. Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 13442, 107 Stat. 568, amending 26 U.S.C. 162(n). That amendment apparently motivated many providers of health coverage to continue paying the surcharges. See Travelers Br. in Opp'n 2.

respect to . . . payment[s] made from the Fund.' " Pet. App. A15. The court also noted that, "[e]ven if [it] agreed that the language of § 8909(f)(1) is ambiguous," it would still "defer to OPM's interpretation of its own regulation" and hold the surcharges preempted. *Id.* at A17. The court therefore affirmed the district court's holding that FEHBA preempts the 11% and 13% surcharges, insofar as they apply to rates for services covered by FEHBA. *Ibid.*

DISCUSSION

The court of appeals held that the surcharges imposed under New York's comprehensive regulation of in-patient hospital charges "relate to" ERISA plans and are not preserved from preemption by ERISA's insurance savings clause. The holding that the surcharges are preempted creates a conflict with a decision of the Third Circuit that a similar New Jersey scheme that sets hospital rates in part on the basis of the nature of the payor is not preempted by ERISA. In our view, the Second Circuit's decision erroneously expands ERISA's preemption provisions and, as a consequence, improperly confers an immunity for ERISA plans from generally applicable state laws that have only an indirect economic effect on ERISA plans. The court of appeals' decision is of particular importance, because it imposes unwarranted limits on the ability of the States to experiment with a variety of approaches to regulate the health care market in order to control costs and ensure that health care coverage is widely available. Further review is therefore warranted.

The court of appeals also held that New York's surcharges are preempted by FEHBA. That holding is correct and does not conflict with any decision of any other court of appeals. Because FEHBA's preemption provision differs substantially from ERISA's preemption provision, review of the court of appeals' FEHBA holding would not illuminate the ERISA

issues in this case, but would instead serve to add additional and unnecessary complication to what is already a highly complex case. Accordingly, further review of the court's FEHBA preemption holding is not warranted.

1. The Second Circuit's ruling that ERISA preempts the hospital surcharges imposed by New York law because they have an indirect economic impact on ERISA plans conflicts with the Third Circuit's decision in *United Wire, Metal & Mach. Health & Welfare Fund* v. *Morristown Memorial Hosp.*, 995 F.2d 1179, cert. denied, 114 S. Ct. 382 (1993). That case concerned New Jersey's hospital rate system, which—like that of New York—was based on a DRG rate, subject to various adjustments. Among the adjustments were some that raised the DRG rates for all payors and then redistributed the extra proceeds to hospitals that suffered losses because they provided uncompensated care or treated Medicare patients at lower payment rates. 995 F.2d at 1189. Other adjustments provided for a discount to high-volume health plans, such as Blue Cross, and for an 11% discount to plans with open enrollment. *Id.* at 1190.

The Third Circuit held that the payment scheme did not "relate to" an ERISA plan within the meaning of ERISA's preemption provision. The court reasoned that New Jersey's regulatory scheme was "a statute of general applicability that [was] designed to establish the prices to be paid for hospital services, which [did] not single out ERISA plans for special treatment, and which function[ed] without regard to the existence of such plans." 995 F.2d at 1192. Recognizing that the New Jersey statute could have increased the cost of hospital services for ERISA plan participants, the court viewed "[t]his effect [a]s no different in kind * * * from any state regulation that increases the cost of goods or services that hospitals consume and pass on in hospital costs." *Id.* at 1193. The court further observed that the New Jersey statute did "not direct ERISA plans to structure their benefits or

conduct their internal affairs in any particular way," and did not impermissibly impede the interstate operation of ERISA plans, especially because the cost of hospital services varies from region to region in any event. *Ibid.* Under those circumstances, the court concluded that any "indirect ultimate effect of increasing plan costs" was insufficient to justify preemption. *Ibid.*; see *id.* at 1195.

Like the New Jersey statute at issue in *United Wire*, the New York statutes at issue in this case are laws "of general applicability": the various surcharges apply to categories of payors—*i.e.*, commercial insurers, HMOs, the Blues, self-insured plans, etc.—that are defined without regard to whether they provide health benefits for ERISA plans or participants in ERISA plans; petitioners assert —and respondents do not dispute—that each of the categories of payors in fact provides health benefits for both ERISA and non-ERISA plans and participants. See 93-1414 Pet. 4-5 & n.4; 93-1408 Pet. 14-15. The effect of the New York regulatory scheme, like that of the New Jersey scheme, is simply to vary the cost of hospital services for various payors. The New York statutes do not direct ERISA plans to provide any type or level of benefits. Nor do they impermissibly impede the interstate operation of ERISA plans, which—as the Third Circuit recognized—in any event must take into account widely varying hospital costs. In short, the New York statutes' effect on the ERISA plans at issue here is the "indirect ultimate effect of increasing plan costs." Yet, while the Third Circuit held that effect to be insufficient to warrant preemption in *United Wire*, the Second Circuit in this case reached the opposite conclusion.

Indeed, the Second Circuit recognized that its decision appeared to conflict with *United Wire*. Pet. App. A25 n.3. The court noted, however, that the Third Circuit had relied in part on a prior Second Circuit decision, *Rebaldo* v. *Cuomo*, 749 F.2d 133 (1984), cert. denied, 472 U.S. 1008 (1985), that the

Second Circuit in this case found to have been superseded by this Court's intervening decision in *Ingersoll Rand*.[3] Pet. App. A21, A25 n.3. The Second Circuit's repudiation of *Rebaldo* does not, however, mitigate the circuit conflict. To the contrary, the differing views of the two circuits about the continuing validity of the reasoning of *Rebaldo* simply mirror the difference between the circuits concerning whether a law of general applicability whose only effect on ERISA plans is on the cost of health services is preempted.

In any event, the Third Circuit made clear that it was relying on the reasoning of *Rebaldo*—not the fact that it continued to carry precedential weight in the Second Circuit. See 995 F.2d at 1193-1196. Indeed, each circuit has been quite express in acknowledging its disagreement with the other. The Third Circuit in *United Wire* expressly disagreed with the district court's decision in this case, see 995 F.2d at 1194 n.8—a decision whose reasoning was adopted in large part by the Second Circuit. And the Second Circuit expressed the view in this case that, aside from the disagreement about the continuing validity of *Rebaldo*, "[m]ore generally * * * the Third Circuit reads ERISA's preemption clause too narrowly." Pet. App. A25 n.3.[4]

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[3] *Rebaldo* upheld as not preempted by ERISA "a New York statute setting the rates that hospitals in that state had to charge patients, including those who were participants in self-insured employee benefit plans," in part on a theory that only statutes that "purport to regulate" ERISA plans are preempted. See *United Wire*, 995 F.2d at 1193. *Ingersoll-Rand* discredited that theory, see 498 U.S. at 141, as both the court below and the court in *United Wire* understood. Compare Pet. App. A21 with 995 F.2d at 1194-1195. The Second and Third Circuits, however, explicitly disagree on whether *Rebaldo*'s reasoning retains validity in other respects.

[4] The HMO respondents state (HMO Br. in Opp'n 14 n.6) that the Third Circuit "retreat[ed]" from *United Wire* in *Travitz* v. *Northeast Dep't ILGWU Health & Welfare Fund*, 13 F.3d 704, cert. denied, 114 S. Ct. 2165 (1994). *Travitz* had nothing to do with hospital cost regulations or, indeed, with regulation of the health care market. Instead, *Travitz* involved a state

2. The Third Circuit correctly rejected the proposition that state regulation that has an indirect and solely economic impact on ERISA plans is necessarily preempted. That conclusion follows from this Court's decision in *Mackey* v. *Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 831 (1988), which repudiated the notion that the "substantial administrative burdens and costs" incurred by benefit plans subject to Georgia's general garnishment statute sufficed to bring the law within the "relate[s] to" language of Section 514(a) of ERISA. Similarly, in *Ingersoll-Rand*, on which the court of appeals purported to rely, this Court made clear that it was not "dealing * * * with a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan," and that the statute at issue there did more than simply add an additional "cost" to the plan's "administrative burden." 498 U.S. at 139.

To the extent that they apply to commercial insurers or HMOs, the only effect that the surcharges in this case have on ERISA plans is both indirect (because the surcharges do not apply to plans themselves, but are generally applicable to insurers and other health carriers whose services are purchased both by ERISA plans and others) and solely economic (because the surcharges affect only the costs of services ERISA plans purchase, and thus do not dictate the type or nature of benefits that ERISA plans may or must offer to participants or regulate how an ERISA plan must be

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statute that precluded an individual injured in an automobile accident from recovering medical expenses from the tortfeasor if the individual was otherwise eligible to receive medical benefits from any "program, group contract, or other arrangement," 13 F.3d at 708, including an ERISA plan. The Third Circuit held the statute preempted by ERISA and, in a footnote, noted that *United Wire* was "inapposite on its facts" to the statute at issue in *Travitz*. 13 F.3d at 710 n.5. The footnote in *Travitz* does not suggest any alteration in the Third Circuit's position concerning whether hospital cost regulations of the sort at issue in this case are preempted by ERISA.

administered).[5] Insofar as the surcharges affect the rates charged by various health insurers and HMOs, they may influence plan choice. But there is a legally significant difference between a law that directly limits plan choice by mandating which benefits it must or must not purchase, *e.g.*, *Metropolitan Life Insur. Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985), and a law that has an indirect and solely economic impact on ERISA plans by affecting the price of services or commodities purchased both by ERISA plans and by others in the State. Because the surcharges at issue in this case fall into the latter category, they do not "relate to" the ERISA plans at issue in this case and they therefore are not preempted.[6]

3. We also disagree with the Second Circuit's conclusion that, if the 13% and 11% surcharges were found to "relate to" ERISA plans, they would not be saved by ERISA's insurance savings provision.[7] The Second Circuit believed that, as a

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[5] Application of the 13% surcharge to "self-insured funds" may raise some distinct issues, since that surcharge applies to bills that some ERISA plans—those that self-insure—must pay themselves, rather than to bills that are paid by commercial insurers, HMOs, or the Blues, who in turn contract with ERISA plans and others. This case, however, does not present those issues. None of the plaintiffs in this case is a self-insured fund, and none of them thus appears to have standing to challenge the application of the 13% surcharge to self-insured funds.

[6] In the court of appeals, the Secretary of Labor, appearing as amicus curiae, expressed the view that indirect economic impact is not a sufficient basis for ERISA preemption, but that the limitation of plan choice provided a sufficient connection to trigger preemption. He took the position that the surcharges "relate to" ERISA plans on that narrow ground, but that—except for self-insured ERISA plans, which are protected by the "deemer clause"—they are saved from preemption by the insurance savings clause. The discussion in text now represents the position of the Secretary.

[7] By virtue of ERISA's "deemer" clause, 29 U.S.C. 1144(b)(2)(B), see *FMC Corp.* v. *Holliday*, 498 U.S. at 61-65, the analysis of whether the 11% and 13% surcharges are saved with respect to self-funded ERISA plans

matter of common sense, the 11% and 13% surcharges regulate hospital rates, not the insurance industry. Pet. App. A26-A27. In our view, that view is mistaken. Both surcharges are "specifically directed" toward the insurance industry, *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. at 50, because the determination whether a payor must pay either surcharge turns wholly on the payor's status as a participant in the insurance marketplace, not on any factor concerning the nature of the hospital or of the medical service provided. In addition, the primary function of the two surcharges is to reduce the differential in insurance rates to account for the greater costs the Blues and some HMOs incur as a result, *inter alia*, of their open-enrollment and community-rating policies. That purpose is closely tied to the traditional function of insurance regulation: to affect the ways in which risks are spread. Accordingly, the 11% and 13% surcharges are reasonably viewed as insurance regulation.

The Second Circuit also erred in holding that the 11% and 13% surcharges satisfy only one of the three McCarran-Ferguson factors—"whether the practice has the effect of transferring or spreading a policyholder's risk." *Pilot Life*, 481 U.S. at 48. The court held that the surcharges do not satisfy the second McCarran-Ferguson factor because they "do not regulate any practice that is integral to the insurer-insured relationship." Pet. App. A28. Because the surcharges are premised on the open enrollment and community rating policies of the Blues and HMOs, they can be said to regulate the relationship between the insurer and the insured.

The Second Circuit finally held that the 11% and 13% surcharges fail to satisfy the third McCarran-Ferguson

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may be different from the analysis of whether they are saved as applied to other payors. Questions concerning the "deemer" clause, however, are not presented by this case, since no self-funded ERISA plan is among the plaintiffs.

factor because they "involve entities" that—in the court's view—are "beyond the insurance industry," such as "the State, hospitals, patients, HMOs, and self-insured funds." Pet. App. A29. The fact that the surcharges in some sense "involve" patients, hospitals, and the State, however, is of little significance. Insurance regulation generally is intended to have an effect on the customers of insurance companies—in this case, hospital patients—and to carry out the public policies of the State. So long as the amount of the surcharges is determined solely by the nature of the payor—*i.e.*, the payor's role in the insurance industry—the fact that hospitals collect the surcharges, and that the proceeds of the 13% surcharge are retained by hospitals, is not dispositive.

The court also erred in holding, as a matter of law, that HMOs are not part of the insurance industry for purposes of ERISA's insurance savings provision. See Pet. App. A26 n.5, A29 n.6. An HMO combines the function of an insurer (since for a set price it assumes the risk that a person will need medical care) and a provider of medical care (since it generally either provides the medical care itself or arranges for others to provide the care). Therefore, insofar as a State regulates the HMO in its role as insurer—which the 11% and 13% surcharges, by exempting HMOs, do, in the same way that they regulate the Blues—it is appropriate to view the surcharges as an aspect of the regulation of insurers for ERISA preemption purposes. That conclusion is buttressed by the language of the ERISA savings clause, which sweeps somewhat more broadly than the McCarran-Ferguson Act. The ERISA clause applies to "any person" subject to insurance regulation; by contrast, the McCarran-Ferguson Act's grant of authority to the States to regulate insurance is restricted to "[t]he business of insurance, and every person engaged therein." 15 U.S.C 1012(a). Especially in light of that difference, the court erred in concluding that the fact that the 11% and 13% surcharges have an effect on HMOs means that

the surcharges are not "limited to entities within the insurance business." Pet. App. A29.[8]

4. The issue on which the Second and Third Circuits are divided is of substantial importance. Since most health care is paid for through employee welfare benefit plans as a fringe benefit of employment, virtually every state regulation of a variable that operates in the health care marketplace would appear to satisfy the Second Circuit's "substantial economic impact" test, and therefore to be inapplicable to ERISA plans under the Second Circuit's decision in this case.[9] That consequence is already manifest in the Second Circuit, which recently held in *NYSA-ILA Medical & Clinical Servs. Fund* v. *Axelrod*, 27 F.3d 823 (1994), that a labor-management ERISA-covered fund that operates clinics for participating union members did not have to pay a generally applicable—if "de minimis," see 27 F.3d at 828—0.6% assessment on hospital revenues. Relying on the decision in this case, see *id.* at 827, 828, the court reasoned that because the assessment "targets only the health care industry," which "by definition" is "the realm where ERISA welfare plans must operate, the

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[8] Because the court of appeals found—incorrectly, in our view—that HMOs "do not engage in the 'business of insurance' as a matter of law," Pet. App. A29 n.6, it did not reach the further question of whether the particular characteristics of the 9% surcharge render it a "law * * * which regulates insurance" within the meaning of the insurance savings clause. In our view, a law regulating HMOs *can* constitute a "law * * * which regulates insurance" under some circumstances. Accordingly, if this Court determines that the 9% surcharge "relates to" ERISA plans, it should remand the case to the court of appeals for a determination of whether the particular characteristics of the 9% surcharge applicable to HMOs bring it within the insurance savings clause.

[9] The district court acknowledged that all state hospital rate-setting statutes will "relate to" employee benefit plans—and hence will be subject to ERISA preemption—insofar as "they apply to rates charged to patients that are participants in ERISA plans which include hospital expenses as a benefit." Pet. App. A77-A78.

[assessment] was bound to affect" ERISA plans. *Id.* at 827. Because the ability of States generally to regulate large segments of the health care marketplace may turn on whether the Second Circuit's or the Third Circuit's view of the scope of ERISA preemption is correct, further review by this Court is warranted to resolve the conflict between the two circuits.

Respondents argue (Travelers, etc., Br. in Opp'n 2-3) that this case is likely to have little continuing significance, since the 11% surcharge has already expired and most ERISA plans are currently paying the 13% surcharge because of a congressional enactment giving such plans a tax incentive to do so. See note 5, *supra*. The tax incentive expires, however, on May 12, 1995, see *ibid.*—a date that serves to afford petitioners an opportunity to obtain review in this Court while the 13% surcharge remains in effect. Thus, New York's ability to collect the 13% surcharge after that date—and, consequently, its ability to enforce its all-payor hospital cost-control program—hinges on the result in this case. In addition, the Second Circuit's decision in this case may have a substantial effect on the ability of other States in that Circuit to regulate medical costs. See, *e.g.*, *New England Health Care Employees* v. *Mount Sinai Hosp.*, 846 F. Supp. 190, 195-198 (D. Conn. 1994) (relying on the decision in this case to hold that portions of Connecticut's hospital cost regulatory scheme are preempted under ERISA). Finally, the disposition of the enormous sums of money that have been paid into escrow under the 11% and 9% surcharges remains at issue in this case. See 93-1414 Pet. 6 n.5; 93-1415 Pet. 17 n.16; HANYS Reply Br. 6-7.[10]

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[10] The pendency of health care reform proposals in Congress does not alter our view that certiorari is warranted in this case. If Congress enacts health care reform legislation before the end of this Session—and if such legislation appears to affect the ERISA preemption analysis in this case—

5. The Hospital Association of New York State (HANYS) alone seeks review of the court of appeals' determination that FEHBA preempts the 11% and 13% surcharges. See 93-1415 Pet. 22-25. The court of appeals' ruling with respect to the FEHBA preemption issue is correct and does not conflict with any decision of another court of appeals. Accordingly, further review of that ruling is not warranted.

As the court of appeals explained, petitioner HANYS "do[es] not dispute that the 13% and 11% surcharges satisfy the first two requirements for preemption: the surcharges are a state-imposed 'tax, fee, or other monetary payment,' and they are imposed 'directly or indirectly' on carriers offering FEHBA plans." Pet. App. A14 (quoting 5 U.S.C. 8909(f)(1) (Supp. IV 1992)). The FEHBA preemption dispute in this case thus turns on whether the surcharges are levied "with respect to any payment made from the Fund." 5 U.S.C. 8909(f)(1) (Supp. IV 1992).

Relying on a "straightforward construction" of the statutory language, the court of appeals concluded that the surcharges are imposed "with respect to * * * payment[s] made from the Fund" and hence are preempted by Section 8909(f). Pet. App. A15-A16. In our view, the court correctly rejected HANYS's argument (93-1415 Pet. 23-25) that Section 8909(f) is limited to "premium taxes," at least in any narrow sense of that term. The text of Section 8909(f) makes no reference to premium taxes. And although there are references to premium taxes in the legislative history of Section 8909(f), the court of appeals correctly explained that HANYS's resort to legislative history in this connection is "singularly unenlightening" because "it remains obscure what the various members of Congress *meant* when they referred to 'premium taxes.'" Pet. App. A16.

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the case could of course be remanded to the Second Circuit for reconsideration in light of the newly enacted legislation.

HANYS's attempted reliance on 48 C.F.R. 1631.205-41 (1992), the OPM regulation implementing Section 8909(f), is misconceived for similar reasons. The OPM regulation merely uses the term "premium tax" as a shorthand description of the taxes covered by FEHBA's preemption provision. Contrary to HANYS's position, the regulation stresses the broad preemptive sweep of Section 8909(f), interpreting it to apply to "*all* payments directed by States or municipalities, regardless of how they may be titled, to whom they must be paid, or the purpose for which they are collected," including "*all* forms of direct and indirect measurements on FEHBP premiums, *however modified*" (emphasis added). Nothing in the regulation suggests that Section 8909(f)(1) applies only to the narrow class of premium taxes suggested by HANYS. The court of appeals correctly concluded that there is no conflict between the regulation and OPM's formal opinion letter to New York, and the court properly held that OPM's interpretation of its own regulation is entitled to deference.

Even if the court of appeals' disposition of the FEHBA issue were incorrect, there would be no reason for this Court to review that issue here. As HANYS concedes (93-1415 Pet. 22), the court of appeals' decision on the FEHBA issue does not conflict with the decision of any other court of appeals; no other court of appeals has had occasion to address the issue. Moreover, the FEHBA issue has no relationship to the ERISA preemption issue in this case. Although HANYS now suggests otherwise (HANYS Reply Br. 8), HANYS itself told the court of appeals that, "[w]ith respect to preemption, the two statutes have entirely different provisions. Preemption under ERISA does not equate to preemption under FEHBA." HANYS C.A. Pet. for Reh'g, at 14. The ERISA preemption analysis presents complex and significant legal issues. Granting review of an additional, wholly unrelated issue would serve only to unduly complicate the parties' presentation and the Court's consideration of this case.

CONCLUSION

The petitions for a writ of certiorari in Nos. 93-1408 and 93-1414 should be granted. The petition for a writ of certiorari in No. 93-1415 should be granted, limited to the first question presented.

Respectfully submitted.

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APPENDIX

1. ERISA Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A), provides in full:

> Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

2. ERISA Section 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B), provides in relevant part:

> Neither an employee benefit plan described in section 1003(a) of this title, * * * nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, * * * or to be engaged in the business of insurance * * * for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts * * *.